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Top Ten Ideas For Enhancing Mission, Culture and Leadership

By Richard L. Buck, MD, MPH, FACPM

Captain, Medical Corps, U.S. Navy
Commanding Officer
Naval Hospital Pensacola

I believe that all of us, whatever our positions, can and should enhance the mission, culture and leadership of our organizations. One of my hopes in putting together this article is that it will serve as a catalyst to generate at least one idea that you will choose to implement to enhance the mission, culture and leadership in your organization. I have organized this article using a "top ten" format. For each idea, I will describe it briefly and then suggest a reference that provides additional information.

1. Be "The Very Definition of Integrity"

I put this idea first because I believe that integrity is the bedrock of a mission, culture and leadership that is successful and sustainable. I believe that each one of us, whatever our level in the organization, can be "the very definition of integrity." I also believe that integrity grows from the small things that we do or don't do every day.

The wording for this first idea comes from an outstanding chapter, "The Very Definition of Integrity," in an equally outstanding book **Nobody In Charge: Essays on the Future of Leadership** by **Harland Cleveland**. In the chapter, Cleveland describes what he calls "The 'Will I Still Feel' Question." His point is that the question to ask, when making a decision, is NOT will I be criticized - he goes on to state, especially if operating in an area of public responsibility, the answer to that question is quite likely to be yes. Cleveland says that to him the illuminating question is "If this action is held up to public scrutiny, will I still feel that it is what I should have done and how I should have done it?" The two parts of the question force one to look at both the ends and the means to those ends.

2. Be A "Servant-Leader"

Right behind integrity for me, comes "Be a Servant-Leader."

Robert Greenleaf, who introduced the concept of **Servant Leadership** in his now classic book by the same name, said that the servant-leader is servant first:

> "It begins with the natural feeling that one wants to serve, to serve *first*. Then conscious choice brings one to aspire to lead. That person is sharply different from one who is *leader* first, perhaps because of the need to assuage an unusual power drive or to acquire material possessions. For such it will be a later choice to serve - after leadership is established. The leader-first and the servant-first are two extreme types. Between them there are shadings and blends that are part of the infinite variety of human nature."

Greenleaf goes on to say that the difference manifests itself in the care taken by the servant-first to make sure that other people's highest priority needs are being served. The best test, and difficult to administer, he says, is:

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To build trust, a leader must exemplify competence, connection and character.

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"Do those served grow as persons? Do they, *while being served*, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?"

Once you are committed to being a "servant-leader" and a servant first, the transition to seeing "Through Patient's Eyes" is a natural one.

3. If You Are Not Having Fun, You Are Not Doing It Right

Idea Number 3, along with ideas 4 and 5, are the three elements of my Command Philosophy that provide a common framework for carrying out our mission at Naval Hospital Pensacola.

Naval Hospital Pensacola's goals are to provide health services that are safe, effective, patient-centered, timely, efficient and equitable - at world-class levels.

I don't believe you can do anything at "world-class" levels without having fun in the sense of joy in what you do. That joy encompasses opportunities for personal and professional fulfillment. Part of that joy, and part of doing it right, is treating each other and those we serve with dignity and respect. Doing it right is listening to understand, not to refute.

I include under doing it right, taking time to "recharge" on a regular basis; a belief that part of the energy and enthusiasm that one brings to work comes from the activities and roles that one has outside of work.

A book on leadership that discusses the elements of having fun and doing it right, as well as several other of the ideas discussed in this article, is **It's Your Ship** by **Michael Abrashoff.** I recommend this book on a regular basis, and many people who tell me that they normally don't read or particularly enjoy books on leadership have told me that they loved this book.

4. The Main Thing Is To Keep The Main Thing, The Main Thing

The underlying assumption in this statement is that one knows what the main thing is. I think that defining the "main thing" in a way that everyone in the group or team can conceptualize and operationalize is key.

To me, "keeping the main thing, the main thing" also involves "systems thinking" where one sees one's efforts as part of efforts of the systems in which one operates. I like the phrase "Preserve the Core/Stimulate Progress" from the business classic **Built to Last** by **James Collins** and **Jerry Porras.** That phrase captures the idea that having defined the "main thing" and working to keep it the "main thing," we also need to be open to change in how to accomplish the main thing. The book has outstanding examples of companies that have done just that for over 50 years.

5. "I Go Where The Puck Is Going To Be, Not Where It Is"

This is the reported response of Wayne Gretzky, the highest-scoring player in the history of the National Hockey League, when asked how he scored so many goals. To me, this statement emphasizes that we must always be looking for the next opportunity even while, in fact especially while, current efforts are successful.

The paradox is that the best time to go "where the puck is going to be" is when you are

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Captain Richard Buck
Naval Hospital Pensacola
Pensacola, Florida

Captain Buck is the commander of The Naval Hospital of Pensacola. During his tenure, the staff have received the Navy Surgeon General's Award of Excellence in Force Health Protection, were recognized by the Assistant Secretary of Defense for Health Affairs for being in the top ten percent of all military treatment facilities in patient satisfaction, received an award from the Picker Institute as the United States' most patient-centered hospital in continuity and transition of care, and were the recipients of the Picker International Symposium Institutional Award for Advancement of Patient-Centered Care.

Captain Buck graduated from Dartmouth College, attended Trinity College in Oxford as a Marshall Scholar where he obtained an M.A. in Physiology, and has studied at Imperial College in London where he was awarded an M.Sc. in Biochemistry. A graduate from Stanford University Medical School, he also completed a year as an Assistant Resident in Internal Medicine at Yale-New Haven Hospital which was followed by a residency in Preventive Medicine at Yale University, where he was awarded an M.P.H. in Epidemiology.

Captain Buck is Board Certified in Preventive Medicine, a Fellow of the American College of Preventive Medicine, and is a graduate of the Program of Management in Health Care, University of North Carolina Kenan-Flagler Business School at Chapel Hill. Captain Buck has written and lectured in the areas of preventive medicine and medical management.

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extremely successful at where the puck is now. This is a point that **Charles Handy** makes in his superb book the **Age of Paradox** in a chapter titled "The Sigmoid Curve." He states that you need some of the upward momentum from the current success to offset some of the initial downward momentum that is inherent in any change. If you wait until you are on the downward slope from a previous success to institute change, you will have both the downward momentum of the idea whose time has passed as well as the initial downward dip inherent in implementing any change.

6. Be Geese, Not Buffalo

This phrase is a reference to the book **Flight of the Buffalo** by **James Belasco** and **Ralph Stayer**. The title refers to the fact that buffalo are loyal followers of one leader and in the absence of that leader will stand around not knowing what to do. Contrast that, they say, with geese flying in their "V" formation - the leadership changing frequently with different geese taking the lead. For this to happen, each bird must know the "common destination."

Developing "lead geese" becomes a metaphor for developing and encouraging leadership at all levels of the organization. Belasco and Stayer believe that those who do the job know how to do it best. Combine that specific knowledge with understanding the "common destination" and you have the potential for "lead geese" at all levels of the organization.

7. Play Off The Same Sheet Of Music - Like A Jazz Group

This idea reflects my belief that an analogy for today's world-class organization - an organization that can adapt, innovate and remain aligned - is a jazz group. In a jazz group, sometimes all of the musicians are playing at the same time; sometimes only one or two are playing together. There is improvisation and others may pick up on that riff and develop it. For all of this variation, the playing is not random; there are rules.

The concept of simple rules to facilitate both alignment and innovation is extremely well presented by **Paul Plsek** in Appendix B of **Crossing the Quality Chasm** titled "Redesigning Health Care with Insights from the Science of Complex Adaptive Systems." The point is that a few well-chosen simple rules can lead to complex and innovative system behavior with overall alignment.

8. Ask the Three "E" Questions On A Regular Basis

The three "E" questions come from a presentation I heard by the late analyst Carl Builder.

The three questions look at strategic, operational and tactical issues of the organization.

In my experience, we are often most comfortable and often tend to focus most on the Tactical "**E**" question "How **E**fficient are we?" Efficiency measures, such as how many patients did we see today, do not require any feedback from patients and in this way are process measures.

Builder's operational "**E**" question is "How **E**ffective are we at what we are doing?" Note now that to look at operational measures for the same areas we looked at tactically, we would need feedback from patients. For example, regarding patient visits: while it is enough to look at numbers to measure efficiency, we need to ask patients if those visits met their needs to determine if our visits were effective.

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Top Ten Ideas for Enhancing Mission, Culture & Leadership

"The best executive is the one who has sense enough to pick good men (people) to do what he (they) wants done, and self-restraint enough to keep from meddling with them while they do it."

Theodore Roosevelt

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Personnel determine the potential of the organization

Relationships determine the morale of the organization

Structure determines the size of the organization

Vision determines the direction of the organization

Leadership determines the success of the organization

John C. Maxwell, "The 21 Irrefutable Laws of Leadership"

"A leader is one who sees more than others see, who sees farther than others see, and who sees before others do."

Leroy Eims

The Strategic "**E**" question is "What is the business of the **E**nterprise?" This encompasses the work that Stephen Covey refers to as Quadrant II activities, work that's "important, not urgent" and hence the one that often receives the least attention. With this question we are reviewing the aspects of our operations and asking should we still be continuing to do them and, equally important, are there new activities that we should be doing.

For an excellent discussion of metrics and their use, I recommend the book by **Mark Brown** titled **Keeping Score: Using the Right Metrics to Drive World-Class Performance.**

9. All Teach, All Learn

This is a favorite phrase of one my heroes in the healthcare improvement movement, Don Berwick, CEO of the Institute for Healthcare Improvement.

To me, what that phrase means is a commitment to "a learning organization." **Peter Senge,** in his classic book **The Fifth Discipline,** says that the basic meaning of a "learning organization" is:

"An organization that is continually expanding its capacity to create its future. For such an organization, it is not enough merely to survive. 'Survival learning' or what is more often termed 'adaptive learning' is important - indeed it is necessary. But for a learning organization, 'adaptive learning' must be joined by 'generative learning' - learning that enhances our capacity to create."

For adaptive and generative learning to both exist, I believe that an essential ingredient is the concept of "All Teach, All Learn."

10. "We Must Be The Change We Wish To See In The World"

This quote from Mahatma Gandhi is a call to be proactive.

Stephen Covey, in his book **The Seven Habits of Highly Effective People,** describes the habit of being proactive. He discusses the "Circle of Concern" and the "Circle of Influence." He makes the point that, for almost all of us, our "Circle of Concern" is larger than our "Circle of Influence."

To me, the essence of being proactive is that by focusing on our "Circle of Influence" and "being the change we wish to see" inside that circle; we can continue to enlarge our "Circle of Influence" and, by doing so, lessen the difference between our "Circle of Influence" and our "Circle of Concern."

Those are my top ten ideas for improving mission, culture and leadership - ideas that I believe are applicable at whatever level we are in our organizations. I am a true believer in "All Teach, All Learn"; so I look forward to hearing your thoughts and ideas on this topic in future issues of this newsletter. Also you can contact me at Richard.L.Buck@pcola.med.navy.mil.

(Footnotes)

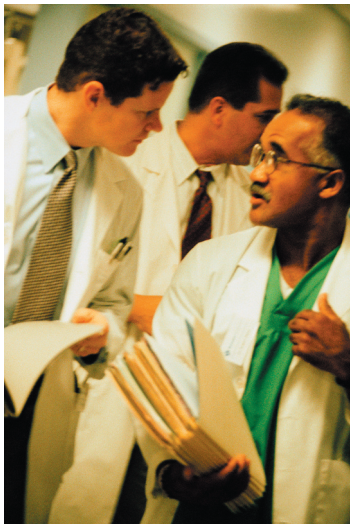
The views expressed are those of the author and do not necessarily reflect the views of the U.S. Navy or the Department of Defense.

What is Corporate Culture?

Thomas A. Atchison
President - Atchison Consulting Group
Oak Park, Illinois

Corporate culture is: "The way we do things around here." It is the way we behave toward the people we serve.

An easy way to understand corporate culture is to compare it to the human personality. All humans have personalities. All organizations have corporate cultures. But have you ever seen yours or anyone else's personality? No, because our personalities are intangible. Corporate culture is the most important intangible to the success of any organization. But if we can't see personalities or corporate cultures, how do we know they exist?



The answer: through the way we behave. We watch someone behave over time and in multiple settings, and we interpret his or her personality, i.e., that person is aggressive, or this is a caring person. It's the same with organizations.

The behavior of employees defines the corporate culture. For example, the way staff behave at the Disney property in Orlando, Florida, and the way they behave at the Disney property in Los Angeles is identical. Disney has a very strong corporate culture based on customer service. The degree to which patients and other customers experience consistent behaviors from your staff at your hospital is the main determinant of your corporate culture's strength.

Where does corporate culture originate? Once again, using the personality analogy is helpful. Our personality began forming in infancy. Our parents had a set of values or beliefs that they thought should govern our behavior. They systematically encouraged behaviors that reflected their values and discouraged any behavior that was not consistent with their beliefs. This socialization process of converting our parents' values to behaviors takes many years.

The same pattern of development drives the creation or strengthening of a corporate culture. The hospital or system has a set of board-approved core values. The process of converting these words to behaviors is called cultural transformation. The hospital must create an environment that encourages those specific behaviors that demonstrate its espoused values and discourages any behaviors that run counter to these values.

Another important way in which corporate cultures are like our own personalities is their resistance to change. One of the easiest ways to identify the specific, unique elements of a corporate culture is to watch what happens during change. Strong cultures actively resist changes that run counter to the values the staff considers most important. Once again, a parallel process happens with individuals. We will fight hard to keep and/or protect those behaviors and supporting values we believe are most important.

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MARCH PSLN SCHEDULE:

Friday, March 19, 2004
11:00 AM - 12:00 PM CT
"Information & Education"

Donna Falvo, RN, PhD

Donna Falvo is a registered nurse, licensed psychologist, and certified rehabilitation counselor. She has been a staff nurse, nursing instructor, counselor, and Professor of Family and Community Medicine, as well as of Rehabilitation Counseling. The author of numerous articles on patient education and patient compliance, she was named a Mary Switzer Scholar in 1986 and was elected to Sigma Xi National Scientific Research Society in 1995. She served for 4 years as Chair of the Society of Teachers of Family Medicine's Group on Patient Education and served for 6 years on the Steering Committee for the Annual National Patient Education Conference sponsored by the American Academy of Family Practice and Society of Teachers of Family Medicine. In addition, Dr. Falvo has been an invited speaker at a number of national patient education conferences and workshops. She was elected president of the American Rehabilitation Counseling Association in 1998. Dr. Falvo currently serves on the Editorial Board of the Rehabiltation Counseling Bulletin and is author of two books, both in their third edition, "Effective Patient Education: A Guide to Increased Compliance" and "Medical and Psychosocial Aspects of Chronic Illness and Disability." She currently lives in Chapel Hill, North Carolina, where she works as a consultant.

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Two questions are most often asked about corporate culture:

1. How do we create a strong culture or strengthen the one we have?
2. How can we change our culture?

In fact, the same process is used to build a new culture or strengthen a current culture. The critical ingredient in both cases is leadership. In health care, this starts with the board's approval of mission and values. This mission-driven, values-based corporate culture is expressed through the CEO's vision. The trustees define the mission and articulate the values. The CEO's main responsibility is to create a vision in context with the organization's mission and in context of its values.

The importance of alignment between governance and executive management on the issues of mission, values, and vision cannot be overstated. Misalignment makes a strong culture impossible and greatly increases the likelihood of conflict. How often have we read that a CEO has left because of a disagreement about "philosophy"?

The behavior of the CEO determines the degree to which the staff will live the values. When the CEO and the other senior executives "walk the talk," powerful cascade effects occur. All staff will imitate leaders they respect and believe. Behavioral inconsistency at the senior level typically results in multiple subcultures, where each subgroup's performance is more important than the organization's performance. Turfs and intergroup conflicts occur frequently in this situation.

Corporate cultures, by their nature, resist change. But change is possible.

Attempts to shift the mission, values, or vision quickly create a complex of traumas that force staff to worry: "Will I have a job? What will they do next? Don't they ever listen to the people who actually do the work?" These and other similar questions indicate that change is happening too fast and has not been adequately explained to the staff in a meaningful way.

Individuals work in an organization, of course, for financial gain. But people also work for "psychic income." Psychic income is the result of those feelings that come from meaningful work and from being surrounded by people who share our values. Corporate cultures thrive when trustees and executives focus on the "corporate soul." (See "Striking a Balance," Trustee, July/August 2001; or go to the archives at www.trusteemag.com.) When people working in a strong culture see how the change "fits" with what they believe, change is easy. They must see the payback in terms of psychic income. That is, "how do these changes affect me?"

Corporate culture drives decisions about hiring and firing, policies, promotions, and strategy. It is the invisible infrastructure for work. It is the company's personality.

April 2002 *Trustee*

learning network
EXPERIENCE THE SYMPOSIUM THROUGHOUT THE YEAR

Patient-Centered Culture and Role of Leadership at UPMC Presbyterian Shadyside Hospital

Beth Kuzminsky, RN, MSN
Clinical Design Program Manager
University of Pittsburgh Medical Center: Presbyterian Shadyside

The Clinical Design Initiative (CDI) has existed since 1998 at UPMC Shadyside Hospital campus. Creation of practice changes that are new and innovative drive CDI improvement work. The approach used to design change in the institution is dramatic, rapid and different from typical models. CDI strives to achieve large amounts of work in a small amount of time. Work of CDI focuses on change that considers patient satisfaction and staff satisfaction, striving to achieve the best balance of both, and recognizes when one outweighs the other.

Strong, supportive leadership is the key ingredient in successful, forward moving CDI work. Without support, knowledge, and resource support from Vice President of Patient Care Services, Tami Merryman, CDI work would not be possible. Specifically, the Care Delivery Structure trialed in 2002 would have been extremely difficult to implement without leadership's driving force. We took a unit that shared Nursing Assistants (NAs) across several Registered Nurses (RNs) and created teams with one NA and one RN assigned to a group of patients.

Why implement "Care Partners"? Direct observation of front line nurses doing their work revealed that RNs perform large amounts of NA work. This occurs because NAs are shared among several nurses and are frequently tied up with one RN, leaving other RNs without NA support. This creates a two-fold problem:

1. RNs spent time "hunting" for supplies/equipment needed to do their work and "hunting" for NAs.
2. Nurses must do NA work which holds them back from providing care/procedures that only an RN can perform and from spending more time at the bedside with patients - the ultimate goal of this initiative.

To improve the current condition, CDI worked with front line staff with support from leadership and did the following:

1. Partnered one RN with one NA
2. Clarified RN and NA roles
3. Created a highly specified Resource Nurse role
4. Created a highly specified Support NA role

Nursing leadership was closely involved as these developments impacted nurse/patient ratios significantly. At such a critical time of change, nursing leadership had to "win over staff" as nurses went from caring for 5-6 patients to caring for 7 patients. It was imperative for leadership to explain that RNs would now have their own NA, and they would no longer have to take time away from "RN" work to hunt for NAs or do NA work. In studying this phenomenal change on this surgical unit, it was clear that key ingredients are needed from leadership to "make it happen."

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PSLN CALL FOR PAPERS

The Picker Symposium Learning Network is accepting abstracts for written presentations on innovative strategies to improve the patient experience through the Picker Institute Eight Dimensions of Patient-Centered Care. Preference will be given to highly skilled papers that address innovation, best practice, future orientation, and measurable outcome demonstration within their dimension.

Email submissions to:
Picker Symposium Learning Network
PSLN@PickerEducation.com

*Please title all emails "Call for Papers"

GUIDELINES FOR SUBMISSION

Abstracts must be typed. Only electronic submissions will be accepted; all pieces are subject to editing.

Abstracts must address one of the Picker Institute Eight Dimensions of Patient-Centered Care.

Papers for any of the eight dimensions of patient-centered care may be accepted at any time, and may be included in a PSLN Newsletter associated with a different dimension of patient-centered care.

Abstracts for a particular dimension must be received two weeks prior to that dimension's publication.

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Roles of Leadership - the key ingredients include:

1. Vice President Tami Merryman's promise to staff: "If it doesn't work, we can always go back to the way it was." In this promise was the strong commitment to staff saying: I'm in this with you, I am not going to force anyone to do anything that doesn't work—a key strategy to building leadership to staff trust.

2. Open Door/Communication Policy: This was more than staff coming to leadership - it is leadership saying, "I'm here!" Tami Merryman came to the "shop floor" where the work happens daily rather than expecting staff to find her. The adopted slogan became "bother the boss."

3. Attendance/Visibility Staff Meetings: Sole purpose is to field staff questions/concerns. Again, Tami was there to respond to questions and concerns of staff. She was not there to lecture.

4. Moving Obstacles: Merryman promised staff that if they 'pulled the vertical chain', she would come to help tackle the problem within the hour. Leadership is the only team that has the authority to have people "jump" when a need arises. The vertical chain is our way of saying "call in leadership now" to help us achieve the goal.

5. Devoting Resources: Leadership provided resources to facilitate change when needed. With the start of CDI, Ms. Merryman had the foresight to devote two FTE's out of her administrative team to work on redesign. Her thinking was that all of the managers have improving processes as a core responsibility of their work but seem to never get to the work on a consistent, 'make it happen' level. By devoting FTE's, this work gets done – the devoted redesign staff partner with the department leadership and together they drive the change home. CDI never takes the place of the department leader but offers support for the people who know the work to make the changes. Through the 6 years of CDI, the two FTE's salaries have been realized in the savings they have made in improvements.

Some modifications and changes have been made to the Care Partners initiative since its inception to accommodate the changing patient population and acuity, which drive staffing needs on the unit. What hasn't changed is the leader's role in continuing to play a critical part in the ongoing refinement and resolution of issues related to change and redesign efforts.

Patient Centeredness

One of the main goals that drive improvement work at UPMC Presbyterian Shadyside Hospital is Patient Centeredness. The Care Partners model has reflected this goal. Giving nurses back the time they spent doing NA work or hunting for NAs shifts more of their time to direct patient care activities.

UPMC Shadyside Hospital was selected in October 2003 as one of the three hospitals in the country to work with The Institute for Healthcare Improvement and Robert Wood Johnson Foundation on a national project called Transforming Care at the Bedside (TCAB). The nature of this project is to develop one or more models of care at the bedside on a medical surgical unit that will result in improved quality of patient care and service, improved staff retention, and greater efficiency.

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PSLN SCHEDULE:

Friday, March 19, 2004
11:00 AM - 12:00 PM CT
"Information & Education"
Donna Falvo, RN, PhD

Friday, April 9, 2004
11:00 AM - 12:00 PM CT
"Access to Care"
Karen L. Miller, PhD, RN, FAAN
Michael R. Bleich, PhD, RN, CNAA, BC

Friday, May 14, 2004*
11:00 AM - 12:00 PM CT
"Respect for Patient's Values, Preferences & Needs"

Friday, June 11, 2004
11:00 AM - 12:00 PM CT
"Continuity & Transition"
SueEllen Pinkerton, RN, PhD, FAAN

Tuesday, July 13, 2004
1:30 PM - 6:00 PM ET
PSLN Congress at the 10th Annual Picker Institute International Symposium - Boston, MA

Friday, August 13, 2004*
11:00 AM - 12:00 PM CT
"Emotional Support"

Friday, September 10, 2004*
11:00 AM - 12:00 PM CT
"Involvement of Family & Friends"

*TENTATIVE DATE & TIME

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Patient Centeredness is one of five main goals of this project. Other Key Design Themes of the TCAB project include: Reliability, Vitality and Increased Value. The first phase of TCAB efforts have been on "prototypes" (experiments) that are changes in the way care is delivered to better meet the needs and /or involve patients in care. Once a prototype has been ruled successful, it is spread to a larger population. Several prototypes at our TCAB site have focused on Patient Centeredness.

Two examples include:

1. Patient Liberalized Diets: The idea was to do away with "strict" diets and empower the patient to *choose* meals without editing from the dietary department. We began with those ordered "*Regular Diets*" and have expanded to the "*Healthy Heart,*" "*Softs,*" "*Mechanical Softs,*" *and "ADA/concentrated sweets" diets.* The dietary department now visits patients two hours prior to meals to obtain selections from a restaurant style menu for the next meal. An evening "*snack basket*" provides patients on the liberal diet a wide variety of snack options (pretzels, cookies, or fruit…) Patient selections are monitored by dietary staff to assess the patient's nutritional habits in relation to their disease process. Consistently "poor" selections triggers an educational consult with a dietician.

2. Questions About My Care Tablets: These booklets are placed in all patient rooms to remind patients and families to write down questions they have for their caregivers. The goal is to meet patient needs by promoting patients to ask caregivers questions they have as caregivers are at the bedside. Nurses routinely ask patients if they have written any questions in their tablet to encourage discussion and use of the tool.

These are just two examples of Patient Centeredness efforts we have engaged in, in the TCAB project. We continue on a daily basis to look for improvement opportunities in this area.

For further information, please contact the Clinical Design Program at UPMC Shadyside Hospital at 412-623-3954.

Picker Institute Annual Award For The Advancement of Patient-Centered Care

The Mission of the Picker Institute is to identify and promote "best practices" that will lead to the advancement of Patient-Centered Care. Two awards shall be made annually, one to an individual and the other to an Institution, to recognize each one's outstanding contribution to improving the lives of patients by making interaction with the health care system less stressful and more comfortable.

The INDIVIDUAL AWARD is awarded to an individual whose professional work has substantially improved care through the "patient's eyes" and has contributed to keeping patient-centered care at the forefront of the health care agenda.

The INSTITUTIONAL AWARD is awarded to an organization that has had one of the best overall scores using the Picker family of patient experience surveys being used in organizations throughout the United States, United Kingdom, Germany, Sweden, Switzerland and Canada.

The organization must also be able to demonstrate that its work on patient-centered care has resulted in improvement of the survey process and impacted the patient experience in other organizations

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Innovative Education for Improving Patient-Centered Care

Yosef D. Dlugacz, PhD
Senior Vice President of Quality Management
North Shore - Long Island Jewish Health System

In my position as Senior Vice President, Quality Management, for a vast and diverse health care system, I have seen the changes that have occurred over the past decades regarding the methodology of evaluating and improving the quality of care delivered to patients – from the assumption that quality was defined by compliance with regulations and a model that identified individual problems and resolutions to identifying problems through monitoring and evaluating corrective actions. These frameworks evolved into a Total Quality Management model for performance improvement, based on the industrial principles developed in the 20th century by such quality leaders as Deming, Juran, and Crosby. The Quality Management approach relied increasingly on measurements and a system's analysis of problems and issues.

The evolution of quality from addressing a single problem with an individual physician to monitoring and evaluating the management of a disease process has sensitized me to develop processes and measurements that can explain clinical phenomena. Today, in light of public pressure to understand performance and the use of quality indicators to measure performance and the provision of a safe environment, Quality Management has evolved even further to embrace more sophisticated methodologies.

In the 18-hospital North Shore – Long Island Jewish Health System, my staff and I work to establish uniform definitions for indicators, educate caregivers on the importance of measuring care objectively, and develop databases to monitor and measure clinical processes. These measures help to define intelligent decision-making and allow top leadership, including the CEO and the Board of Trustees of the health care system, to prioritize learning and an environment conducive to teaching.

This leadership commitment to promoting education has led to the establishment of a "corporate university," the Center for Learning and Innovation, with senior staff named as Deans of their respective disciplines: Quality Management, Finance, Planning, and Human Resources.

Through the Center, all staff is educated on Quality Management philosophy and principles, as well as on tools to assess and oversee performance. Through this education, the culture of the health care system is changing because a common agenda, improving patient-centered care, is promoted.

The two-day Quality Management seminar provides the historical background for how medical care was evaluated and outlines contemporary concepts of Quality Management, such as data analysis, principles for prioritization, information for performance decisions, evaluating best practices and the critical importance of communicating information effectively. The professional staff, as students, are required to develop a performance improvement project which illustrates their command of the material. They use Quality Management methods to demonstrate improved patient care and increased safety provided to the patient. Students are taught the PDCA cycle for performance improvement, a methodology that has been derived from scientific management, and has proven effective in many industries. The system is also using newer business concepts, such as Six Sigma, to address such processes as Emergency Room turnover time, compliance with discharge instructions, and effective utilization in discharge planning.

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Picker Institute Annual Award For The Advancement of Patient-Centered Care

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This year the awards will be given at the Elegant Evening Event at the 10th Annual Picker Institute International Symposium where the recipients will be publicly recognized, in front of their peers, for their outstanding contributions.

In addition to being publicly cited for outstanding service to the well-being of patients, the recipients of the Picker Institute Annual Award will receive a $10,000.00 cash prize, and free Picker Institute International Symposium registration and tuition, including travel expenses (In the case of an Institution, the Symposium expenses will be paid for its representative.

Nominations for the Award are sought from those within the health care system in any country that has a systematic method for evaluating quality of patient-centered care.

Please contact the Picker Symposium Educational Products at 800-388-4264 for more information.
You may also email PickerSymposium@PickerSymposium.com

Nomination forms and supporting documentation must be received at the Picker Institute offices no later than March 1st.

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The institutional commitment to educating everyone regarding objective standards of care and aggregating information so that disease management is improved has led to such performance improvement activities as analyzing suicide in the behavioral environment, targeting the geriatric population for improvement in mental status, mobility, and skin care maintenance, assessing the safety and sterility of the Operating Rooms, and defining best practices through an analysis of sentinel events.

A legacy is created only when a person puts his/her organization into the position to do great things *without* him/her.

In order to understand how to improve patient care, adverse events are analyzed through performing Root Cause Analysis. The Quality Management seminar also teaches how to use the fishbone diagram to understand which processes, individuals, or organizational procedures influenced an outcome. In addition, flow charts are used to map the patients' and providers' experience along a continuum of time, so that gaps in the delivery of care can be identified. Even potential problems are proactively addressed through the Failure Mode and Effects Analysis methodology.

Measuring quality indicators enables comparison of care delivery across the 18-hospital system and over time. The measures are communicated and shared throughout the system via the sophisticated quality management committee structure. Improvements and best practices that are identified, such as antibiotic administration before surgery, become hospital policy after being endorsed by the medical boards and the Board of Trustees. The measurements are derived from a comprehensive database that is an essential tool to draw conclusions about best practices. The databases that the students are exposed to in the Center for Learning create a scientific aura around the complex field of patient care.

Caregivers across the system have been sensitized to identifying best practices and working to promote a safe environment for every patient. Care has been improved especially for high risk populations because care is analyzed in the aggregate, rather than on the individual level. Vulnerable patients who enter our system are treated as partners in their care, educated regarding the processes and procedures they can expect, and informed about their recovery. Because leadership recognizes the value of information so that patients can make informed decisions regarding their care, the system has agreed to participate in several national initiatives that publicly report data on the quality of care of certain specific diseases. Education, therefore, addresses the needs of the patient, the professional staff, and the organization. Everyone involved benefits.

Yosef D. Dlugacz, Ph.D., is Senior Vice President Quality Management for the North Shore – Long Island Jewish Health System. He is Dean of Quality for the Center for Learning and Innovation. Dr. Dlugacz is an internationally renowned scholar and teacher. He has been a distinguished guest professor at Beijing University, China, in Helsingborg, Sweden, and throughout the United States, Europe and the Middle East.

The Quality measurements and processes that he has developed have been recognized as best practices by the Joint Commission on Accreditation of Healthcare Organizations. Dr. Dlugacz has published extensively on how to integrate Quality across diverse health care systems. His book, The Quality Handbook for Health Care Organizations: A Manager's Guide to Tools and Programs (2004, Jossey-Bass), provides the basic principles and tools of Quality Management in the delivery of patient-centered care.

"You have achieved excellence as a leader when people will follow you everywhere if only out of curiosity."

Colin Powell

KEY DATES

For the 10th Annual Picker Institute International Symposium

April 1, 2004
Early-Bird Registration Deadline

June 15, 2004
General Registration Deadline

July 1, 2004
Late Registration Deadline

July 14-16, 2004
10th Annual Picker Institute International Symposium
Boston, MA

10th Annual Picker Institute International Symposium

Elegant Evening Event

Wednesday, July 14, 2004

The John Joseph Moakley United States Courthouse will be the site of our elegant evening event during the 10th Annual Picker Institute International Symposium.

The John Joseph Moakley U.S. Courthouse has played a key role in rejuvenating the redevelopment of Boston's Fan Pier and Fort Point Channel and serves as headquarters for the United States Court of Appeals for the First Circuit and the United States District Court for the District of Massachusetts. The building houses two courtrooms for the Court of Appeals and 25 courtrooms for the District Court, as well as 40 judges chambers, a Circuit law library, the office of a U.S. Congressman, and extensive support facilities for the U.S. Marshals Service and Pre-Trial and Probation services. The courtrooms themselves are distinguished by a motif of large arches defined by wood moldings and stenciled ornaments, dignifying equally all the participants - judge, jury, witness, litigants, lawyers, spectators - in the proceedings that take place therein.

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